Sun Life Financial

SPONSORED GROUP TERM LIFE

APPLICATION FOR GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

SELECT AMOUNT OF COVERAGE DESIRED

NOTE: For new enrollments, requests for addition of dependents and/or changes, indicate the total amount of insurance desired.

EMPLOYEE OR SPOUSE SCHEDULE OF INSURANCE

(select/check one)

Schedule		Amount
1	❑	$10,000
25	❑	$25,000
50	❑	$50,000
100	❑	$100,000
150	❑	$150,000
200	❑	$200,000
250	❑	$250,000
300	❑	$300,000

PREMIUMS TO BE PAYABLE BY WAY OF:

❑ **Payroll Deduction**
If this payment mode is elected, your application must be processed through your school business office if available.

❑ **Quarterly-Direct Payment**
If this payment mode is elected submit your application directly to MEA Financial Services, Inc.

OFFICE USE ONLY

Current coverage: _____

Effective date: _____

Certificate number: _____

Approved: _____

Entered: _____

Home office: _____

❑ **NEW ENROLLMENT**
- ❑ Employee
- ❑ Spouse/Partner to a Civil Union of Employee **(must complete separate application)**

COVERAGE REQUESTED
- ❑ Life Only
- ❑ Life and Accidental Death & Dismemberment
- ❑ Dependent Child(ren) Coverage * (no AD&D)

❑ **CHANGE**
- ❑ Add Dependent Child(ren) *
- ❑ Delete Dependent Child(ren)
- ❑ Change Coverage Schedule *
- ❑ Change of Name

*Dependent Life Insurance is available under either employee or spouse coverage – **not both.**

1. Applicant's full name _____
Last *First* *Middle Initial* *Social Security number*

2. Address _____
Street or P.O. Box *City* *State* *Zip*

3. Beneficiary's full name and relationship _____
Supersedes any prior designation. The Insured Applicant is the beneficiary for dependent insurance.

4a. Name of employer or school _____ **4b.** _____
If applying for Spouse coverage give name of Employee's employer *Employer's phone number*

4c. Hire date ____/____/____ **4d.** Occupation _____ **4e.** _____
Of Employee *Of Employee* *Employee's home/cell phone number*

5. If applying for spouse coverage, give **employee's** name and Social Security number _____

6. Health and personal history (complete the following for all those applying for coverage requiring underwriting)

Failure to provide complete responses will result in underwriting delays or non-payment of claims. This request for coverage is not effective until approved in writing by The Company. No information provided by you or your agent shall bind The Company unless you provide such information in writing on this form. No agent or broker has authority to alter the contents of this form.

	First Name	Last Name	DOB	Height	Weight	Gender
Applicant			(__/__/____)			❑ M ❑ F
Child 1						❑ M ❑ F
Child 2						❑ M ❑ F
Child 3						❑ M ❑ F
Child 4						❑ M ❑ F

Have you or any of your dependents, if applying for dependent coverage, ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	Applicant YES	Applicant NO	Child(ren) YES	Child(ren) NO
1. Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)?	❑	❑	❑	❑
2. Stroke, transient ischemic attack (TIA), high blood pressure, irregular heartbeat, heart murmur, aneurysm, heart attack, angina, elevated cholesterol, or any blood, heart, or blood vessel disorder?	❑	❑	❑	❑
3. Cancer, leukemia, tumor, neoplasm, nodule or polyp (excluding nasal polyp), pre-cancerous condition, or dysplastic nevi?	❑	❑	❑	❑
4. Diabetes, hepatitis, or other disorder of the liver or pancreas; thyroid, pituitary or other endocrine disorder; ulcer, colitis or Crohn's disease, diverticulitis, or other gastrointestinal disorder?	❑	❑	❑	❑
5. Disorder of the kidney, bladder (excluding healed bladder infections) or urinary system, or reproductive organs?	❑	❑	❑	❑
6. Asthma, bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, sleep apnea, cystic fibrosis or any lung or respiratory disorder?	❑	❑	❑	❑
7. Arthritis, rheumatism, or gout; back, neck, or disc disorder; disorder of the knee, muscles, joints, or bones; systemic lupus erythematosus; connective tissue disease; or fibromyalgia?	❑	❑	❑	❑
8. Headaches, epilepsy, seizures, paralysis, memory loss, intellectual disability, amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease), multiple sclerosis, muscular dystrophy, or any brain or neurological disorder, chronic infection, or chronic fatigue?	❑	❑	❑	❑

(Continued on the next page)

Please remit completed application to:
MEA Financial Services, PO Box 2501, East Lansing, MI 48826-2501

Sun Life Financial

In the last 10 years have you or any of your dependents ever been diagnosed with any of these ailments, received medical advice or sought treatment for:	Applicant		Child(ren)	
	YES	NO	YES	NO
9. Skin disorder that lasted for more than 6 months?	❑	❑	❑	❑
10. Anxiety, depression or any mood, emotional, mental, or nervous disorder; post-traumatic stress disorder; or schizophrenia?	❑	❑	❑	❑
11. Disorder of the eyes and ears (excluding healed ear infections)?	❑	❑	❑	❑
12. Blood, pus or sugar in the urine, chest pain, shortness of breath, enlarged glands or lymph nodes, night sweats or unintentional weight loss?	❑	❑	❑	❑

In the last 10 years have you or any of your dependents:	Applicant		Child(ren)	
	YES	NO	YES	NO
13. Consulted a medical professional for anything other than the conditions previously identified in this Health Questionnaire?	❑	❑	❑	❑
14. Been advised to have, or have scheduled, a consultation, surgery, or test that has not been completed or that has been completed but has resulted in symptoms for which you have not consulted a medical professional?	❑	❑	❑	❑
15. Been off work for more than 5 consecutive days due to an illness or injury?	❑	❑	❑	❑
16. Been advised to reduce your consumption of alcohol or to seek counseling for the use of alcohol or drugs; or used cocaine, narcotics, barbiturates, amphetamines, hallucinogens, or other drugs, except as prescribed by a physician; or been arrested in connection with alcohol or drugs; or received treatment in connection with alcohol or drugs?	❑	❑	❑	❑
17. Pled guilty to, pled no contest to, or been convicted of a felony; or been convicted of a major moving violation, including DUI, reckless driving, and driving to endanger; or had your driver's license suspended?	❑	❑	❑	❑
18. Had any screening or diagnostic tests for cancer or heart / circulatory disorders?	❑	❑	❑	❑
19 Are you or one of your dependents currently pregnant?	❑	❑	❑	❑

Have you or any of your dependents:	Applicant		Child(ren)	
	YES	NO	YES	NO
20. In the last 2 years, piloted an aircraft, engaged in motor vehicle racing, auto racing, boat racing, hang gliding, parachuting, climbing, scuba diving, or any other similar sport or avocation?	❑	❑	❑	❑
21. In the last 12 months, used any tobacco products, including cigarettes, cigars, and chewing tobacco, or used nicotine gum or a nicotine patch?	❑	❑	❑	❑
22. In the last 3 years, have you been prescribed or advised to take any medication by a medical professional?	❑	❑	❑	❑

7. Details (provide details below for all questions answered "yes.")

If additional space is needed, please attach, sign, and date an additional sheet including all required information.

Question Number	Applicant Name	State and provide details for each condition and activity	Date condition began	Duration of condition & treatment	Physicians name address & phone	Fully Recovered?
						❑Yes ❑No
						❑Yes ❑No
						❑Yes ❑No
						❑Yes ❑No
						❑Yes ❑No

Please provide physician information even if you answered "no" to all questions.

Name and address of physician with your most up-to-date and compehensive medical records.

Please remit completed application to:
MEA Financial Services, PO Box 2501, East Lansing, MI 48826-2501

8. Acknowledgement, authorization for release and disclosure of health related information and signature

Acknowledgement
I acknowledge, to the best of my knowledge and belief, that:

- The information I have provided in the Evidence of Insurability Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application, and understand that any false statements or misrepresentation made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read, or had read to me, the fraud warning for my state.

I also confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada or Sun Life and Health Insurance Company (U.S.) ("The Company") determines that I am not insurable. If The Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask The Company in writing to: (a) obtain certain information from the EOI Application file relating to me (a fee may be charged); (b) correct, amend or delete information in the EOI Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the EOI Application file relating to me is incorrect; and (d) provide me with a copy of my EOI Application.

If I have any questions regarding my EOI Application, I can write to Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481.

Acknowledgement, authorization for release and disclosure of health related information and signature, continued

I authorize any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy benefit manager or other medical or health care facility that has provided payment, treatment, or services to me or on my behalf, to disclose my entire medical record and any other protected health information concerning me to the Medical Underwriting Department of Sun Life Assurance Company of Canada or Sun Life and Health Insurance Company (U.S.) ("The Company") its subsidiaries, affiliates, third party administrators, and reinsurers.

I understand that such information may include records that relate to my physical or mental condition, such as diagnostic tests, physical examination notes and treatment histories, and that may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs, and tobacco, but does not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Company will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that the Company will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Sun Life Financial, Group Medical Underwriting, P.O. Box 81344, Wellesley Hills, MA 02481, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

9. Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

mea Financial Services

Sun Life Financial

_____ ____/____/____
Signature of Applicant Date

_____ ____/____/____
Signature of Employee Date
(if applicant is spouse/partner to a civil union)